Published in final edited form as:

J Psychoactive Drugs. 2012 ; 44(3): 224–236.

Perceptions of Sober Living Houses among Addiction Counselors and Mental Health Therapists: Knowledge, Views and Perceived Barriers

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Abstract

Affordable alcohol- and drug-free housing that supports recovery is limited in many areas. Sober living houses (SLHs) offer a unique living environment that supports abstinence and maintenance of a recovery lifestyle. Previous studies show that SLH residents make improvements on alcohol, drug and other problems that are maintained at 18-month follow-up (Polcin et al., 2010). However, for SLHs to maximize their impact they must recognize how they are viewed by community stakeholders and successfully address barriers. This pilot study recruited a convenience sample of two stakeholder groups, certified alcohol and drug counselors (N=85) and licensed mental health therapists (N=49), to explore knowledge and views about SLHs using an on-line survey. Therapists and counselors had similar views about SLHs, although counselors had more direct experience with them and were more knowledgeable. Both groups were highly supportive of increasing the role of SLHs to address addiction problems in their communities. Those who were most supportive had more knowledge about SLHs, agreed that alcohol and drug problems were caused by a physical disease, and agreed that successful recovery required an abstinent living environment. Both groups identified a variety of barriers, particularly social stigma. Recommendations are made for knowledge dissemination and decreasing barriers.

Keywords

Sober Living Houses; Therapist Views; Counselor Views; Barriers; Substance Abuse Treatment; Residential Treatment

Studies show that housing status is associated with alcohol and drug use during and after treatment (e.g., Braucht, et al., 1995; Hitchcock, et al., 1995; McLellan et al., 1998; Schinka, et al., 1998). These studies show that individuals completing treatment who return to substance using environments are more prone to relapse than clients living in environments supportive of sobriety. Low income groups, particularly those who have a history of homelessness, are often at the highest risk to relapse because they have few housing options that support recovery from addiction (Polcin, 1999).

Several recent papers (e.g., Polcin, 2009; Polcin & Henderson, 2008) have suggested that sober living houses (SLHs) could play a more prominent role to address the housing needs of individuals attempting to establish and maintain abstinence. SLHs are alcohol- and drug-free living environment for persons attempting to abstain from alcohol and drugs. Because they do not offer formal treatment, they are not licensed by state or local agencies. Instead, they emphasize social model recovery principals, such as 12-step recovery groups and peer support for abstinence. Studies have validated the recovery philosophy of SLHs by showing

that residents who have higher involvement in 12-step groups and social networks supportive of abstinence have better outcome (Polcin et al., 2010). Relative to treatment programs and halfway houses, SLHs have several advantages: 1) Residents can stay as long as they wish provided they comply with house rules, including abstinence from alcohol and drugs. 2) Houses are financed through resident fees so they are not vulnerable to government budget cuts. 3) Residents are typically involved in decision making processes about house operations. Thus, there is a sense of resident empowerment and responsibility for the house (Polcin & Henderson, 2008). SLHs can be organized as for profit or not for profit endeavors and associations such as the California Association of Addiction and Recovery Resources (CAARR) and the Sober Living Network (SLN) are available to certify houses in terms of meeting health, safety, and operational standards. While some individuals enter SLHs after completing residential treatment, others enter while they are attending outpatient programs, after release from criminal justice incarceration, or as an alternative recovery option to formal treatment. Longitudinal studies tracking outcomes of residents in SLHs show they make significant improvements on alcohol, drug, legal, and employment problems and that these improvements are maintained at 18-month follow up (Polcin, et al., 2010).

The Community Context

Finding housing that supports sustained recovery continues to be a major challenge for many individuals with substance use disorders despite recent studies showing positive outcomes for residents in SLHs (Polcin, et al, 2010) and similar housing models such as Oxford Houses (Jason et al, 2006). Our contention is that dissemination of beneficial outcomes will not be sufficient to ensure proliferation of SLHs in communities that need them. To be effective in translation efforts, there must be an assessment of how SLHs are perceived by stakeholders. Recognition that translation efforts must examine community contexts to identify stakeholder perceptions and potential barriers has gained increased attention in recent years (e.g. Guydish, et al., 2007; Jason, et al., 2005; Polcin, 2006).

Two stakeholder groups with a significant investment in SLHs are alcohol and drug counselors and mental health therapists. Few problems are more widespread and frustrating for these professionals than inadequate housing for their alcohol and drug dependent clients.

Alcohol and drug counselors and mental health therapists have a significant influence on SLHs and are in a good position to understand strengths, weaknesses and barriers. Both groups are gatekeepers for SLHs in the sense that they are important referral sources for potential residents. In addition, through their interactions with the clients they serve, clients' families, their own professional associations, and other professional groups (e.g., medical and criminal justice professionals), they influence how SLHs are perceived by the community. However, the extent to which mental health therapists and counselors are accurately informed about SLHs is unclear. It is also unclear how much interaction these professionals have had with SLH facilities and the operators who manage them.

A variety of additional questions relevant to understanding SLHs from the perspective of these important stakeholders remain unanswered. For example, we do not know how readily they view SLHs as a good housing option for the clients with whom they work. We do not know the extent to which therapists and counselors view SLHs as effective or what they think might be potential barriers to operations and expansion. Especially for counselors and therapists who are knowledgeable and familiar with SLHs, how much do they think factors such as social stigma and public policies influence SLHs? Finally, there are questions about the factors that determine counselors' and mental health therapists' perceptions about SLHs. Because counselors and therapists have different training and tend to encounter substance use disorders in different work settings there may be significant differences in their

knowledge and views about SLHs. Other questions include: 1) what is the relative influence of individual characteristics, such as demographics or one's own history of alcohol or drug abuse on views about SLHs? 2) How important is accurate knowledge about SLHs in terms of support for them, and does it make a difference if the professional has more or less contact with facilities and operators?

Purpose

The primary aim of this paper is to report pilot survey data describing the knowledge and views about SLH held by alcohol and drug counselors and mental health therapists. We had two prospective hypotheses about what we expected to find: 1) Counselors and therapists with more knowledge about SLHs, more direct experience with them, and a personal or family history of alcohol or drug problems would have more positive views about them and 2) Social stigma would be identified as a stronger barrier than other factors, such as financial cost to residents, perceptions about how the effectiveness of SLHs, local housing policy, and resistance from neighbors. In addition to our prospective hypotheses, we were interested in exploring how alcohol and drug counselors' and mental health therapists' views about SLHs were similar and different.

Significance

The significance of the study is supported by a variety of factors. First, we aim to better understand obstacles to expansion of SLHs so their numbers might increase in communities where they are needed. Such an expansion could be of enormous benefit to individuals with substance use disorders who do not have access to an affordable alcohol- and drug-free living environment. Examples include clients in residential treatment settings who do not have suitable housing after they leave, clients attending outpatient programs who are living in destructive environments that trigger substance use, and individual who are seeking a non-treatment alternative to recovery.

Second, significance is supported by recent efforts among addiction researchers to emphasize addictive disorders as chronic conditions that require sustained services over time, rather than acute care interventions alone (e.g., McLellan, 2002; Watkins, et al., 2003). Because there is no maximum length of time for residence in a SLH, SLHs are an example of a service that can help sustain long term recovery in the community. Third, recent events within the criminal justice system are likely to increase demand for SLHs. As a result of a recent U.S Supreme Court ruling, over 30,000 offenders in California state prisons will be released into the community (Liptak, 2011). We suggest that SLHs can be an option for some of those offenders being released into the community if they are motivated for recovery.

Finally, public health significance is supported by findings from our earlier longitudinal research (i.e., Polcin et al., 2010). Our study of SLH residents showed significant reduction in problems that plague many communities, including substance use and illegal activities. Because criminal justice and public health programs are underfunded, they do not have the resources to effectively address these problems. We suggest that SLHs can be an important option for reducing crime and substance. However, for SLHs to prosper in communities where they are needed, we need a better understanding of how they are perceived by key stakeholder groups.

Methods

Sample

Participants consisted 134 professionals, 49 licensed or pre-licensed master's degree level mental health therapists (referred to as "therapists" hereafter) and 85 certified alcohol and drug counselors (referred to as "counselors" hereafter). The therapists were recruited primarily from the California Association of Marriage and Family Therapists (CAMFT) and counselors were recruited primarily through the California Association of Alcoholism and Drug Abuse Counselors (CAADAC). A few participants were included who had certifications that were similar to those of CAADAC or CAMFT members.

Procedures

Members of CAMFT and CAADAC were sent an e-mail describing the study and directing them to an online survey website – Survey Monkey (2011) - if they were interested in participating. Once at the site, participants were electronically consented to take part in the study. Completion of the survey required about 20 minutes and participants were compensated \$20 for their time. In addition to recruitment through e-mails, participating therapists and counselors were encouraged to inform colleagues about the study and encourage them to participate (i.e., snowball sampling).

Content of the Survey

Items selected for inclusion in the online survey were based on successful use of similar items in previous studies (e.g., Polcin & Greenfield, 2003; Polcin 2004). See Appendix A for a copy of all survey items. The questionnaire is divided into six parts: 1) "Questions about You," 2) "Questions about Housing for Clients with Alcohol/Drug Dependent Problems," 3) "Questions about Your Beliefs about Alcohol/Drug Problems," 4) "Questions about SLHs," 5) "Questions about Barriers to SLHs," and 6) "Questions about the Role of SLHs in Your Community." With the exception of demographics, most items are rated on a 5-point Likert scale, dichotomous "yes/no" or estimates of percentages.

Analysis

Data analysis began with descriptive statistics (proportions and means for survey items). Bivariate analyses included chi square and independent t-tests, which were used to compare how the two groups of professionals differed on survey items. Selected survey items were combined into 2 scales with composite scores: 1) knowledge of SLHs and 2) the role of SLHs in the community. We used these scales and a selection of other variables to construct a multivariate model examining the relative influence of factors that support SLHs.

Results

This section begins with presentation of data comparing demographic and workplace characteristics among counselors and therapists participating in the survey. We then examine their perceptions about the availability of appropriate housing for their clients who have alcohol or drug problems. Finally, we compare counselor and therapists' general views about the nature and causes of alcohol and drug problems together with views about recovery and the types of services required.

The focus of the section then switches to perceptions about SLHs, where we compare level of knowledge about them, views about things like house operations and the neighborhoods where they are located, perceived barriers, and level of support for SLHs as a valuable recovery service. We end this section with presentation of a multivariate analysis identifying predictors of support for SLHs.

Demographics

Table 1 shows the demographic characteristics of the sample. Over half of the counselors (56%) and over three quarters of the therapists (78%) were women. A large majority for both groups were white, 73% for counselors and 82% for therapists. The average age was older than expected, 51.7 for counselors and 46.6 for therapists. Nearly all therapists had a master's or doctoral degree. In contrast, about three-fourths of the counselors had less than a master's degree.

Table 2 shows how counselors and therapists differed in terms of their workplaces as well as personal and family history of addiction problems. While 68% of the counselors worked in alcohol or drug treatment programs, only 24% of the therapists worked in alcohol or drug programs. Therapists were more likely to be employed in mental health programs (47%) or other settings (35%), which included private practice. In contrast, about 8% of the counselors worked in mental health settings and 23% worked in other settings. While over a quarter of the counselors indicated that over half of their clients were homeless, only 5 (11%) of the therapists indicated a majority of their clients were homeless. Counselors also had larger proportions of clients with a history of homelessness, but the two groups had similar proportions of clients living in unstable situations and environments that promoted substance use.

Large proportions of counselors reported a history of alcohol or drug problems. Over 69% had received treatment and 88% had attended a 12-step meeting. In contrast, relatively few therapists had received alcohol or drug treatment (14%) or attended 12-step meeting (31%). As Table 2 indicates, comparison of these variable by group were significantly different using chi square analysis ($p=.000$ for both comparisons). Family histories of alcohol and drug problems were common for both groups with 95% of the counselors reporting someone in their family suffered from a problem with addiction. The proportion for therapists was similar, (98%). On average, family members who had problems with addiction had a significant impact on the lives of both counselors and therapists. Seventy-nine percent of the counselors and 75% of the therapists indicated a moderate or great impact.

Perceived Scope of Housing Problems

One of our goals was to garner a sense of the extent to which counselors and therapists viewed housing as a problem for their clients and a barrier to recovery. See part 2 in Appendix A for the list of questions addressing housing for clients who have alcohol or drug problems. Counselors and therapists both endorsed the view that housing was a major problem in their work with alcohol and drug abusing clients. For example, both groups on average felt that housing resources were not adequate and they disagreed with a statement that individuals with alcohol or drug problems who want housing can find it. Means on these items were <2.5 on a Likert scale ranging from 1–5 and we did not find differences between counselors and therapists. Other items in Part 2 of the survey assessed how lack of appropriate housing can be an obstacle to recovery. Examples of these items include “housing is a major challenge for clients,” “it is difficult to address alcohol and drug problems if clients are homeless,” and “it is difficult to address alcohol and drug issues if clients live in an environment that promotes alcohol and drug use.” On average, respondents agreed with these types of statements with means ranging from 3.3 (1.19) to 4.4 (sd=1.05) on a 5 point Likert scale. We did not observe significant differences between counselors and therapists on these items. Additional details of findings from Part 2 of the survey can be obtained from the first author.

Views about Alcohol and Drug Problems and Service Needs

Part 3 of the survey addressed respondent's views about alcohol and drug problems more generally, along with beliefs about services needed in treatment. Both counselors and therapists expressed a broad vision of alcohol and drug problems that reflected moderate support for the contention that addiction is caused by biological, emotional, and environment factors. Means for items assessing agreement that these factors are causes of addiction ranged from 3.1 (sd=0.89) to 3.5 (sd=0.54) on a 5-point scale. There was slightly more support for the view of addiction as a physical disease (mean=3.8, sd=1.22 for counselors and mean=3.5, sd=1.04 for therapists). No significant differences between counselors and therapists were noted.

Large proportions of both counselors and therapists indicated that a variety of services are often necessary to successfully treat the clients with whom they work. For example, both counselors (85%) and therapists (75%) indicated alcohol and drug clients frequently or very frequently needed outpatient treatment. Providing an alcohol- and drug -abstinent living environment was viewed as necessary frequently or very frequently by large proportions of both groups (87% for counselors and 80% for therapists). About half of each group felt that medical services were frequently or very frequently needed (56% for counselors and 47% for therapists). Comparisons between counselors and therapists on these variables were not significantly different, nor were measures of views about the need for legal services (55% for counselors and 41% for therapists) and job training (69% for counselors and 61% for therapists).

One area of significant difference in perception of needed services was inpatient treatment. Sixty-nine percent of the counselors, as opposed to 43% of the therapists, felt that clients with alcohol and drug problems needed inpatient treatment frequently or very frequently ($X^2=9.1$, $p=.003$). Another difference was the need for mental health services. Larger proportions of therapists (88%) than counselors (68%) indicated that mental health services were needed frequently or very frequently ($X^2=6.9$, $p=.009$). Finally, there was a significant difference in perceptions about the effectiveness of alcohol and drug treatment. On a 5-point Likert Scale ranging from "Never" to "Always" the mean rating for counselors was 3.5(0.63) and for therapists it was 3.1(0.48). While still moderately supportive of the view that treatment was effective, the therapist mean was significantly lower than that of counselors ($p=.000$). Additional details regarding findings from Part 3 of the survey can be obtained by contacting the first author.

Knowledge about Sober Living Houses

Part 4 of the survey begins with a question asking whether the respondent has heard the term "sober living houses." All but 5 participants responded yes. However, when we asked if they had ever visited a SLH, we found large differences between counselors and therapists. Nearly all of the counselors (95%) but fewer than half of the therapists (45%) indicated they had visited a SLH ($X^2=41.1$, $p=.000$). While nearly 74% of the counselors indicated they referred 20+ clients to SLHs, only 14% of the therapists indicated they referred that number ($X^2=41.5$, $p=.000$). In addition, counselors were more likely to have heard about SLH advocacy groups, such as the Sober Living Network and California Association of Addiction and Recovery Resources. While 69% of the counselors indicated they had heard of SLH advocacy groups, the proportion of therapists indicating they had heard of such groups was only 51% ($X^2=4.2$, $p<.05$).

To assess knowledge about SLHs we constructed a 10-item *Knowledge about SLHs Scale*. All items were taken from Part 4 of the survey (see Appendix A). Means and standard deviations can be found in Table 3. For two items that are dichotomous, chi square analyses

are reported. Items addressed three different areas: 1) experience with SLHs and SLH advocacy groups, 2) objective knowledge about characteristics of SLHs and 3) perceived self-knowledge about SLHs. Each of the items in the scale is indicated below along with where in Part 4 of the survey it can be found.

1. Overall knowledge about SLHs (question 2)
2. Count of items correctly describing characteristics of SLHs (question 3)
3. Visited a SLH (question 5)
4. Knowledge about establishing SLHs (question 12)
5. Knowledge about expanding SLHs (question 13)
6. Maximum length of stay (question 14)
7. Required to participate in chores (question 15)
8. Required to minimize contact with neighbors (question 16)
9. Required to have daily structure such as work or school (question 18)
10. Awareness of SLH Associations (question 27)

To assess internal consistency of the 9-item scale we used Cronbach's alpha, which resulted in an alpha coefficient of 0.69. To calculate a composite score for each participant we used the sum of the 10 items. When we compared counselors and therapists on mean scores for knowledge about SLHs we found counselors were significantly higher (counselor mean=26.9[SD=4.43], therapist mean=20.3[SD=3.8]), indicating more knowledge about SLHs ($t=8.3$, $df=126$, $p=.000$).

Views about Sober Living Houses

Table 4 shows means for counselor and therapist views about various aspects of SLHs. These include: 1) views about operations of the houses, 2) characteristics of appropriate candidates for SLH residence, and 3) the neighborhoods where they are located. On most of these items, counselors and therapists had very similar views. For example, questions addressing operations of SLHs included a question asking whether SLH managers were easy to reach and whether they were vigilant in monitoring visitors who could potentially have a negative influence on residents. Means on both of these items had a narrow range from 3.6 to 3.7 for counselors and therapists.

There was also agreement about appropriate candidates for SLHs. To a moderate degree, both counselors and therapists supported the contention that not all persons with substance use disorders were appropriate for SLHs (mean=3.2 for counselors and 3.5 for therapists), and they both felt more strongly that to succeed residents needed to be motivated to work a recovery program (means=4.4 for both groups).

On items assessing views about SLHs from a neighborhood perspective, counselors and therapists to a moderate degree believed that SLHs were located in safe, affordable neighborhoods that were zoned for single family homes. Both groups had stronger views supporting the contention that SLH look like other houses in the neighborhood, are not more likely than other houses to have residents creating disturbances, and do not have a negative influence on safety, quality of life or property values.

As Table 4 indicates, there were two issues on which counselors had significantly stronger views than therapists. Although therapists strongly felt that SLHs had an appearance similar to other houses in the neighborhood (mean=3.8) counselors had an even stronger view

(mean=4.2) ($p<.05$). Similarly, although therapists disagreed with the view that SLHs have a negative influence on the quality of life in the neighborhood (mean=2.2), even stronger disagreement was expressed by counselors (mean=1.8) ($p<.05$).

Views about Barriers to SLHs

Consistent with one of our a priori hypotheses, both counselors and therapists indicated that the strongest barrier to operations and expansion of SLHs was social stigma (see Table 5). On average, stigma was rated 4.3 on a 5-point scale for both groups, where 5 indicated strong agreement. However, counselors and therapists also felt other barriers were important. Examination of the means for Table 5 indicates that on average every barrier listed was felt to be at least “moderate,” with means all greater than 3 for both counselors and therapists. The N’s for the two groups are slightly lower in these analyses due to missing data (80 for counselors and 44 for therapists).

The most prominent barriers following social stigma were beliefs about the causes of alcohol and drug problems, lack of information about SLHs, and lack of information about how communities can support them. Barriers such as zoning laws, lack of support from local government, and costs to residents were on average rated as moderate to strong barriers, but they were nonetheless weaker than social stigma. For example, on social stigma, over 44% of the respondents indicated the highest possible rating of 5-“very strong.” However, only 16% of the respondents felt that zoning laws were very strong barriers, and 26% felt that costs to residents were very strong barriers. Even resistance from neighbors was lower, where 22% of the respondents indicated such resistance was a very strong barrier.

Two barriers where we found significant differences between counselors and therapists were lack of state government support and lack of research showing they are effective. Although therapists felt lack of state government support was a substantial barrier (mean=3.5, $sd=0.79$), counselors viewed it as stronger (mean=3.9, $sd=1.03$). There was a similar result for research showing effectiveness, where therapists on average rated 3.3 ($sd=1.09$) and therapists rated a stronger level of 3.9 ($sd=1.02$).

Views about the Role of SLHs in the Community

One way we assessed support for SLHs was to examine the perceived roles that counselors and therapists thought SLHs could play in the community. These items consist of the last 5 items at the bottom of Table 6. See Part 6 in Appendix A for the exact wording of each item. The results show strong support for the view that SLHs could play a stronger role in the community. Both counselors and therapists strongly rejected the notion that we have enough SLHs. On items assessing potential ways that SLHs could benefit the community (e.g., decrease homelessness), means for counselors and therapists ranged from 3.5 to 4.3, where 5 indicates stronger positive impact.

There were significant differences on two items, both of which differed only in the extent to which they were supported. Therapists felt that SLHs could play a stronger role as an adjunct to formal treatment (mean=4.0, $sd=0.76$). Counselors held this view to an even stronger degree (mean= 4.3, $sd=0.79$). While both groups felt that state and local government could increase support for SLHs, counselors supported this view more strongly (mean=4.2, $sd=0.82$) compared to therapists (mean=3.8, $sd=0.92$).

Support for SLHs Scale

To construct a measure assessing support of SLHs we combined the 5 items assessing the potential role of SLHs in the community with 2 additional items assessing perceived effectiveness of SLHs and 2 other items assessing SLHs’ impact on the community. Thus,

our support of SLHs measure included three constructs: 1) views about the potential role of SLHs in the community, 2) perceived effectiveness of SLHs for sobriety and stable housing, and 3) perceptions about purported destructive influences of SLHs on the community.

Summary of Items on Support for SLHs Scale

Items for the *Support for SLHs Scale* are taken from Part 4 and Part 6 of the survey. Means and standard deviations for each item can be seen in Table 6. Items for the scale and where each is located in the survey include:

1. Have enough SLHs (Part 6, question 1)
2. SLHs could play a stronger role as adjunct to treatment (Part 6, question 2)
3. SLHs could decrease homelessness (Part 6, question 3)
4. SLHs could play a stronger role as an alternative to treatment (Part 6, question 4)
5. State and local government could increase support for SLHs (Part 6, question 5)
6. Effectiveness for sobriety (Part 4, question 6)
7. Effectiveness for stable housing (Part 4, question 7)
8. Negatively impact on the overall quality of life in the neighborhood (Part 4, question 25).
9. Negative effect on property values (Part 4, question 26)

Cronbach's alpha was used to assess the internal consistency of the items in the scale and yielded an alpha of 0.74. To create a composite scale score we used the sum of the 9 items. When we compare these mean scores for counselors and therapists we did not find significant differences. On average, both groups expressed strong support for SLHs.

Multivariate Model

The goal of the multivariate analysis was to identify the relative influence of different variables on support for SLHs. The dependent variable in this analysis was the composite score from the *Support for SLHs Scale*, which is described above. Because the sample of 124 participants was somewhat limited in terms of statistical power to conduct multivariate analyses, selection of predictor variables needed to be parsimonious. In addition to examining how counselors and therapists differed in their support for SLHs, we were also interested in examining how other variables predicted support of SLHs, such as demographic characteristics, knowledge about SLHs, and attitudes about alcohol and drug problems more generally. Variables with the strongest bivariate associations and variables that represented different domains were selected for inclusion in the model. This method enabled us to examine how different constructs predicted support for SLHs and parse out their relative influences within the multivariate model.

The final multivariate model consisted of 5 predictor variables. In addition to professional group (counselors versus therapists), we selected 4 variables that had significant bivariate associations with the *Support for SLHs* composite score: 1) the 10-item *Knowledge about SLHs* scale, 2) the view that alcohol and drug problems are caused by a physical disease, 3) the view that to succeed in recovery SLH residents frequently need a clean and sober place to live, and 4) age, which was the only demographic characteristic with a significant bivariate association. Although attendance at self-help meetings was significantly associated with support for SLHs ($t=3.0$, $df=122$, $p=.003$), we did not include it in the final model because it was highly correlated with the *Knowledge about SLHs* scale and therefore created problems with collinearity of predictor variables.

Table 7 shows the results of the multiple regression model. The overall model explained approximately 20% of the variance (Adjusted R Square = .20, $F = 7.14$, $p = .000$). When we examined how individual variables predicted support for SLHs we found 3 that were significant: 1) the 10-item *Knowledge about SLHs* scale ($p = .002$), 2) the view that alcohol and drug problems are caused by a physical disease ($p = .013$), and 3) the view that to succeed in recovery SLH residents frequently need a clean and sober place to live ($p = .012$).

Limitations

There are a number of limitations that are inherent in this study. First, participants were self-selected volunteers who logged on to a web-based survey to participate. They therefore do not constitute a representative sample of alcohol and drug counselors or mental health therapists. Relative to others in their professions, it is likely our sample represents counselors and therapists who have more interest, knowledge and involvement in sober living houses. However, an advantage of having better informed respondents is that they are more likely to contribute informed, valid views about SLHs and accurately identify barriers that they have encountered in their work.

A second limitation is that responses are opinions of respondents and not objective measures of variables. An objective analysis of barriers might emphasize factors not endorsed by respondents in the study, and objective assessments of SLHs and their surrounding communities might result in different conclusions about their potential roles. Our survey did not assess the views of other stakeholder groups, such as neighbors, the general public or local officials who develop public policy on housing and substance abuse.

Third, we do not know the characteristics of the houses that respondents considered when they thought about SLHs. They may have been considering the SLHs to which they refer rather than the full panoply of different SLHs that exist. The houses that they are familiar with and to which they refer might not be typical SLHs. As noted in previous reports (e.g., Polcin & Henderson, 2008), SLHs can vary a great deal and not all houses are associated with SLH associations that ensure consistency, such as the Sober Living Network or California Association of Addiction and Recovery Resources.

Finally, the demographics of our sample were largely white. Individuals from different minority groups might have different perspectives not tapped here. The sample was also relatively older than most individuals in the two professions examined, with the average age of therapists being 46 and counselors 51. A younger age group of professionals could potentially respond differently to the survey questions.

Discussion

This study represents an example of an important, yet largely ignored type of research that goes beyond the question of whether interventions work. That is, it examines the community context within which services are delivered. Only by understanding what stakeholders in the community know about interventions and how they view them can we maximize expansion of needed services.

Our results depict views and perceptions about SLHs from two important stakeholder groups: alcohol and drug counselors and mental health therapists. This section begins with a discussion about their knowledge and views about SLHs, perceptions about barriers, and comparisons depicting similarities and differences between the two professions. We then expand the discussion to include depiction of factors that were found to be associated with support for SLHs in our multivariate analysis. Based on our results, we present a number of

suggestions for ways that SLH advocates might target knowledge translation efforts and decrease the strength of barriers that hinder SLH operations and expansion.

Comparisons between Counselors and Therapists

Counselors and therapists both expressed strong support for SLHs despite many individual and professional differences. For example, there were significant differences between counselors and therapists in terms of demographic characteristics, education, workplace characteristics, personal history of addiction treatment, knowledge about SLHs, and level of experience with SLHs. However, both groups expressed that it was often difficult to find alcohol- and drug-free housing for the clients with whom they worked. They also both expressed strong support for a stronger role for SLHs in the community. Overall, each group of caregivers appeared to view SLHs as a valuable resource to support their own efforts to help people.

Counselors and therapists tended to have similar perceptions about how SLHs operate, the types of individuals who are appropriate for them, and how SLHs impact the community. On questions where we found differences it was a matter of degree, not direction. For example, therapists on average supported the view that SLHs looked similar to other houses in the neighborhood and did not have an adverse effect. Counselors simply expressed those views to a stronger degree.

The main areas of difference were on items assessing knowledge and experience with SLHs. These were items that reflected information about rules and policies relevant to living in a SLH as well as personal experiences, such as whether the respondent had visited a SLH. This was an expected finding given that the counselors were trained specifically to treat alcohol and drug disorders and mental health therapists were trained to treat a wide variety of emotional and interpersonal problems. Although the therapists on average had substantial experience with substance use disorders, they clearly were not treating alcohol and drug disorders to the same extent as counselors and therefore had less experience with SLHs.

Counselors and therapists both expressed the view that SLHs faced a variety of strong barriers. On every barrier examined both counselors and therapist had mean ratings above “moderate.” The strongest perceived barriers were those that reflected beliefs and views about alcohol and drug problems among the general public. Consistent with our hypothesis, both groups rated social stigma as the strongest barrier and “beliefs about the causes of alcohol and drug problems” was rated high as well. Relatively weaker barriers were things like zoning laws and resistances from local government. Even resistance from neighbors (NIMBY [not in my back yard]), which has received extensive coverage in popular media in recent years, was rated lower than more global negative views among the public. Thus, the views of respondents seemed to support the contention that negative interaction and conflicts with neighbors were less important than broad, prejudiced views about addictive disorders and the individuals who suffer from them.

When there were differences between therapist and counselor respondents it was once again an issue of degree and not direction. For example, although both groups felt that lack of support from state government and lack of research supporting effectiveness were significant barriers, counselors on average viewed them as stronger than therapists.

Factors Associated with Support for SLHs

Factors that predicted the *Support for SLHs Scale* composite score did not include demographic characteristics or whether one’s profession was that of alcohol and drug counselor or mental health therapist. Rather, support was predicted by knowledge about

SLHs, agreement with a disease model view of addiction and support for the view that a clean and sober living environment is an important component of successful recovery.

It could be argued that our sample consisted of a significant number of respondents who were knowledgeable about SLHs because of a personal commitment to them (e.g., ex-resident, house manager, or friend or family member of a SLH resident). Thus, more knowledge might be associated with a positive bias toward SLHs. However, an alternate explanation is that these types of individuals had first-hand, experiential knowledge about SLHs and were in a good position to recognize their strengths and weaknesses.

Support for SLHs was in part determined by the overarching view of how alcohol and drug problems were conceptualized. When participants viewed alcohol and drug problems as a “physical disease like other diseases” and felt that an abstinent living environment was essential to successful recovery, they were more likely to support SLHs. These findings are understandable because SLHs encourage or mandate involvement in 12-step recovery groups such as Alcoholics Anonymous, which supports the disease model of addiction and encourages development of an abstinent lifestyle.

Other findings that reflected the importance of overarching views about addiction among the general public were participants’ views about social stigma as a prominent barrier. Thus, increasing support for SLHs might be tied to larger goals about educating the public about addiction as a disease rather than a moral failing or bad behavior. The experiences of SLH advocates suggests that SLHs are often opposed by the general public because of widespread fear SLHs will negatively impact the neighborhood (e.g., increase crime) and the values of homes. However, our sample disagreed that these were valid concerns and in fact there is little evidence to substantiate them.

Strategies for Increasing Support for Sober Living Houses

Addressing the issues raised in our survey could take various forms. For example, one strategy might be to increase activities to educate the general public and various professionals who encounter substance use disorders about the scientific basis that supports addiction as a disease. Despite extensive efforts by groups such as the American Medical Association and the National Institute of Health to educate the public about addiction as a disease rather than a moral issue, there continues to be considerable bias and negative judgment toward persons with alcohol and drug disorders (Keyes, et al., 2010).

A related strategy would be to target reduction of social stigma.

One method that has been shown to be effective in decreasing stigma is to orchestrate interaction between stigmatized groups and others in the community (Corrigan et al., 2001). For example, SLH advocacy groups such as the SLN or CAARR could increase their presence in the public media and social network sites. Hearing positive stories about recovery from current and previous residents of SLHs might be a productive strategy. In addition, managers and operators of SLHs might use strategies employed by one of our current study sites, Clean and Sober Transitional Living (CSTL) in Fair Oaks, California. They actively mobilize residents to volunteer to help support local community activities, such as festivals and other celebrations. Residents of the SLHs are then known for their service to the community, which contradicts negative, stigmatizing views held by some members of the community. Similarly, CSTL invites neighbors and others in the community to take part in program social activities and celebrations, such as a Christmas holiday party and a celebration of sobriety event. This allows the community to see the facility and interact with residents within the context of a positive social environment.

Another strategy used by CSTL to garner support that might be used by others is respond quickly to neighbor concerns. Results from our survey suggest that managers are generally easy to reach when there are concerns about any aspect of the house. Responding promptly to neighbor complaints does not necessarily mean that SLHs need to automatically capitulate. Reasonable requests should be accommodated in order to maintain good relations. However, CSTL has had successful experiences informing those opposed to SLHs about things like the fair housing act and zoning laws (see Wittman [2009] for a discussion of these and related issues).

Another strategy to increase support for SLHs is to disseminate a growing body of research to stakeholder groups that describes the characteristics of SLHs and documents favorable outcomes. Although respondents in our survey on average rated “lack of research showing SLHs work” as a moderate to strong barrier, recent studies have documented favorable outcomes for residents of SLHs (e.g., Jason et al., 2006; Polcin et al., 2010). Improvement not only included decreases in alcohol and drug use, but issues of seminal importance to neighbors, such as decreases in illegal behaviors and arrests. Jason et al (2005) studied next door neighbors of Oxford Houses and reported that they had positive views about the houses. Neighbors who lived a block away had no knowledge about an Oxford House in their neighborhood and experienced the house to be similar to others in the neighborhood. These studies need to be more effectively disseminated to SLH advocacy organizations such as the Sober Living Network and the California Association of Addiction and Recovery Resources, as well as treatment professionals and the general public.

Finally, a variety of additional studies could increase our knowledge about SLHs and factors that support and hinder their operations. Our research team is currently assessing views of SLHs from other stakeholders, including house managers, neighbors, and local government officials. This research should help broaden our understanding of factors that facilitate and hinder SLHs.. Results should inform SLH managers about ways to modify their houses and operations to maximize support.

Acknowledgments

Supported by R21DA025208

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TABLE 1

Demographic Characteristics

	Alcohol and Drug Counselors (N=85)	Mental Health Therapists (N=49)
	N (%)	N (%)
Female	47(56)	38(78)
Ethnicity		
Caucasian	62(73)	40(82)
Hispanic	5(6)	1(2)
African American	9(11)	3(6)
Other	9(11)	5(10)
Married or Living with Partner	40(47)	34(69)
Education		
< Master's Degree	64(76)	5(10)
Master's Degree+	20(23)	44(90)
Age, mean years (SD)	51.7(11.1)	46.6(13.9)

TABLE 2**Workplace Characteristics and Alcohol/Drug Treatment History**

	Alcohol and Drug Counselors (N=85)	Mental Health Therapists (N=49)		
	N (%)	N (%)	χ^2	p
Workplace				
Alcohol/Drug Program	58(68)	12(24)	24.7	.000
Mental Health Program	7(8)	23(47)	26.4	.000
Other	19(23)	17(35)		
50% of Clients Homeless	23(28)	5(11)	5.4	.028
50% of Clients Have History of Homelessness	36(43)	7(16)	10.4	.002
50% of Clients Have Unstable Housing	35(45)	28(62)	3.5	NS
50% of Clients Reside in Environment Promoting Alcohol/Drug Use	37(47)	26(58)	1.22	NS
Received Alcohol/Drug Treatment	59(69)	7(14)	40.8	.000
Attended Self-Help Meeting	75(88)	15(31)	47.7	.000
Family Problem with Alcohol/Drugs	81(95)	48(98)	0.65	NS
Drinking/Drug Use Impact Great or Moderate	67(79)	37(75)	5.0	NS

TABLE 3

Knowledge about Sober Living Houses Scale Items

	Alcohol and Drug Counselors (N=85)	Mental Health Therapists (N=49)
	Mean(SD)	Mean(SD)
Likert Scale Items		
Perceived Level of Knowledge about SLHs	4.2(.88)	2.9(1.15) ***
Checklist of Description of SLHs	6.6(1.20)	6.1(1.10) **
Good Understanding of how To establish new SLHs	3.4(1.29)	2.2(1.14) ***
Good Understanding of Things To Support Expansion	3.4(1.04)	2.3(1.04) ***
Residents are Required to Leave after a Period of Time	3.0(1.10)	3.5(0.77) *
Residents are required to Participate in House Chores	4.6(0.54)	4.2(0.76) **
Residents are Required to Minimize Contact with Neighbors	2.7(1.10)	3.0(1.00)
Residents are Required to Work or Attend School	3.7(1.10)	3.6(0.84)
Dichotomous Items		
	Percent	Percent
Ever Visited a SLH	95	45 ***
Heard of SLH Advocacy Associations	69	51 *

p<.001,

**
p<.01,

*
p<.05

Note: Means were calculated on a 5-point scale from "strongly disagree" to "strongly agree."

Dichotomous items were assessed using chi square tests for proportions.

TABLE 4

Views about Sober Living Houses

	Alcohol and Drug Counselors (N=85)	Mental Health Therapists (N=49)
	Mean(SD)	Mean(SD)
Most SLHs Facilitate Referrals to Services	3.2(1.07)	3.6(0.92) *
To Succeed Residents Must be Ready to Work a Recovery Program	4.4(0.93)	4.4(0.79)
Many Individuals Not Ready for SLHs	3.2(1.07)	3.5(0.89)
SLHs are Not More Likely to Create Disturbances	3.5(1.23)	3.5(1.04)
Managers are Easy to Reach	3.7(0.97)	3.6(0.73)
Managers Maintain Close Control Over Visitors	3.6(1.07)	3.7(0.85)
SLHs are Located in Neighborhoods that are Safe and Low Crime	2.8(0.99)	3.0(0.86)
SLHs are Located in Affordable Neighborhoods to Keep Costs Low	3.4(0.76)	3.5(0.62)
SLHs are Zone for Only Single Family Homes	2.9(0.79)	2.9(0.79)
Appearance of SLHs is Typical of Other Houses	4.1(0.62)	3.8(0.73) *

*
p<.05

Note: Means were calculated on a 5-point scale from “strongly disagree” to “strongly agree.”

Table 5**Barriers to Sober Living Houses**

	Alcohol and Drug Counselors (N=80)	Mental Health Therapists (N=44)
	Mean(SD)	Mean(SD)
Neighbors	3.7(0.91)	4.0(0.71)
Local Government	3.3(0.91)	3.4(0.83)
Lack of Information about SLHs	3.9(0.79)	4.1(0.83)
Lack of Information about How to Start SLHs	3.6(1.0)	3.8(1.0)
Lack of Information about How Communities can Support SLHs	3.9(0.79)	4.0(0.78)
Beliefs about Causes of Alcohol/Drug Problems	4.2(0.85)	4.0(1.00)
Lack of government support	3.9(1.03)	3.5(0.79) *
Lack of Research Showing They Work	3.9(1.02)	3.3(1.09) **
Social Stigma	4.3(0.69)	4.3(0.70)
Costs to Residents	3.7(1.04)	3.5(1.00)
Zoning Laws	3.4(1.06)	3.3(1.03)

*
p<.05,

**
p<.01

Note: Means were calculated on a 5-point scale from “not at all” to “very strong.”

Table 6**Support for Sober Living Houses Scale Items**

	Alcohol and Drug Counselors (N=84)	Mental Health Therapists (N=49)
	Mean(SD)	Mean(SD)
Effectiveness of SLHs For Sobriety	3.8(0.86)	3.6(0.63)
Effectiveness of SLHs for Stable Housing	3.5(1.01)	3.6(0.76)
SLHs have a Negative Influence on Neighborhood Safety and Quality of Life	1.8(0.90)	2.2(0.88) *
SLHs Have a Negative Effect on Property Values	2.1(0.93)	2.5(0.87)
Have Enough SLHs	1.33(0.59)	1.32(0.52)
Stronger Role as Adjunct to Treatment	4.3(0.79)	4.0(0.76) *
Could Decrease Homelessness	4.2(0.76)	4.1(0.86)
Stronger Role as Alternative to Treatment	3.5(1.18)	3.8(1.08)
State and Local Government Could Increase Support	4.2(0.82)	3.8(0.92) *

*
p<.05

Note: Means were calculated on a 5-point scale from “strongly disagree” to “strongly agree.”

Table 7**Multiple Regression Analysis of Factors Predicting Support for Sober Living Houses**

Variable	B	SE	t	p
Profession (Counselor versus Therapist)	0.599	0.744	0.81	NS
10-item Knowledge about SLHs Scale	0.240	0.086	2.80	.006
Physical Disease View	0.854	0.399	2.52	.013
Age	0.019	0.033	0.59	NS
Recovery Requires Clean and Sober Place to Live	1.077	0.425	2.53	.012

Note: The overall model with all 5 variables entered resulted in $F = 7.14$ ($p = .000$), adjusted R Square = .20.